

CPA Donald O. Hebb Award for Distinguished Contributions to Psychology as a Science / Prix Donald O. Hebb de la SCP pour contributions remarquables à la psychologie en tant que science

Perfecting, Belonging, and Repairing: A Dynamic-Relational Approach to Perfectionism

Public Significance Statement

This paper provides a review of the perfectionism research, models, and treatment approaches developed by Drs. Paul L. Hewitt, Gordon L. Flett, and Sam Mikail and colleagues. It outlines four streams of research and conceptual work done on perfectionism, a core vulnerability factor in psychological and physical health outcomes as well as relationship, achievement, and treatment outcome problems.

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Abstract

This article is based on my address given at the Canadian Psychological Association annual convention in Halifax, Nova Scotia on May 31, 2019. The address was given on the occasion of my receiving the Donald O. Hebb Award for Distinguished Contributions to Psychology as a Science. In this paper, I will present some of the ideas and work that my colleagues, especially Dr. Gordon Flett and Dr. Samuel Mikail, and I have undertaken in an attempt to gain an understanding of perfectionism, a core vulnerability factor that underscores myriad psychological, physical, relational, and achievement problems. The research and clinical work arising from the work is heavily influenced by my psychodynamic-interpersonal perspective and, generally, includes several major streams of inquiry. These include addressing what perfectionism is; what kinds of distress, dysfunction, and disorders perfectionism is associated with; how perfectionism develops and how it works in producing difficulties; and finally, the development, refinement, and evaluation of a dynamic-relational psychotherapeutic approach for treating per-

fectionistic behaviour. I discuss briefly what we learned in this process both in terms of perfectionism and in terms of attempting to understand a complex and multifarious personality vulnerability factor. Finally, I conclude with briefly acknowledging and describing some of the gifted Canadian researchers across the country who have also been captivated with understanding perfectionism and who have added significantly to our understanding of the construct.


Keywords: perfectionism, perfectionistic behaviour, perfectionistic, psychodynamic

It was my distinct honour to receive the Donald O. Hebb Award for Distinguished Contributions to Psychology as a Science by the Canadian Psychological Association for research done over the past 30 years. Although I am grateful for the honour, it is important to acknowledge that the work upon which the award is based was by no means a solo effort. In undertaking any program of research it is absolutely a team approach and I simply have the privilege of receiving the award for the work that a team of us created and completed over the years. While there are many students and former students who participated as colleagues, my very close association with Dr. Gordon Flett and Dr. Samuel Mikail has been pivotal in the research and this award should be shared among us.

The purpose of this paper is to provide a written version of the address I gave at the annual CPA convention upon receipt of the award. In this paper, I will outline briefly the nature of our enterprise to understand the nature of perfectionism by describing, very generally, four streams of the research and conceptual work conducted and some of the things we have learned along the way, both in terms of the content or knowledge about perfectionism but also the process of engaging in the research and clinical work trying to understand perfectionism.

Before some of the specifics, I would like to acknowledge several important influences guiding this work, and these influences have existed pretty much from the start of my interest in

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perfectionism. First, the psychodynamic/interpersonal theoretical orientation that has informed my research and clinical work on perfectionism arose from my training at the University of Saskatchewan with Dr. Linda McMullen and Dr. John Conway. For those of us lucky enough to have been trained by Drs. McMullen and Conway, we were taught an appreciation both for the layered complexity of people and the depth of understanding needed to comprehend and work with patients to effect significant change. The combination of psychodynamic (e.g., Bowlby, 1988; Horney, 1950; Kohut, 1971; Strupp & Binder, 1984) and interpersonal (Benjamin, 1993; Kiesler, 1996; Sullivan, 1953) theories have always guided the thinking and the development of our models of perfectionistic behaviour and, perhaps most importantly, guided the development of our dynamic-relational individual and group treatment approach for perfectionism (Hewitt, Flett, & Mikail, 2017; Hewitt et al., 2015; Hewitt, Flett, Mikail, Kealy, & Zhang 2018; Hewitt, Qiu, et al., 2019). Moreover, the substantial empirical and theoretical bases to psychodynamic models and treatment (this can sometimes come as a surprise to students and others who have the misinformed impression that there is little or no empirical basis to psychodynamic perspectives and treatments) have also guided our attempts to ensure, hopefully, that we were careful in our research designs and in the development of measures, models, and treatments of perfectionism.

A second powerful influence is best illustrated by an experience I had while working on a suicide project with a colleague at the University of British Columbia, professor emeritus, Dr. Stanley Coren. We were working on a massive database of 10.6 million death records from the United States and as I was doing the analyses—selecting out a sample of records of individuals who had died from suicide—I experienced two powerful emotions. While watching the counter (old SPSS programs had a counter) indicating the number of subjects selected climbed and climbed to upward of 20,000, the researcher in me was extremely excited at the size of the sample and the power we would have in our research. The second emotion, which came a few seconds after the excitement, was the sobering realisation each number indicated, in our wonderfully massive sample, an individual who in some way suffered such profound pain or turmoil that ending his or her life and, very likely, devastating the people close to him or her, was the only perceived option. Sobering, indeed, but also instructive in reminding me that we are always studying people, no matter what level of analysis or investigation or sample we choose. Often in our field, especially when researching personality constructs, syndromes, or diagnoses, the construct, syndrome, or diagnosis becomes reified and the person who actually has the construct, syndrome, or diagnosis in question gets lost or at least recedes in the background. For me, as a team member in the perfectionism research world, if I have contributed any creative elements to the study and understanding of perfectionism it has come mainly from interactions with others who have perfectionistic tendencies. This, of course, is most often from patients who I came to know very deeply and broadly in the longer-term psychodynamic treatment I provide. It is these intricate and personal interactions; getting to know the person in-depth that has deepened my understanding of perfectionism and facilitated the work. Throughout this process, patients taught me what we need to study to better understand perfectionism, its genesis and intended function, and ultimately,

appropriate avenues for treating people who experience its often devastating impact.

Being a clinical psychologist and a scientist practitioner¹ is a privilege in many ways. Doing the clinical work with patients and seeing firsthand the working of the person and the complex construct we are studying have aided immensely. Moreover, the extensive research training we receive affords us a unique way of thinking about clinically relevant phenomena that has certainly shaped how I have come to understand the workings of perfectionism. I would encourage researchers to interact with your research subjects; to bring them into the lab to do the empirically rigorous testing and research, but also to speak with them, and to come to know them. They can teach you about the issue you are studying in many ways. Gordon Flett, I am sure, would agree with me on this, and although as a personality psychologist he does not work clinically with others, he has found creative ways to ensure that he interacts with and learns from perfectionistic individuals in his lab. Indeed, he pours over case studies and autobiographies of individuals with perfectionism, clearly demonstrating his desire to know the people with perfectionism and not simply the construct of perfectionism.

The Work

I am asked very frequently, what is perfectionism? The work I will briefly set out below is our attempt to answer this question. The research we have engaged over the years has, essentially, four streams. The first stream involves trying to describe what perfectionism entails, and the second, what the components of perfectionism are associated with, mostly in terms of the distress, dysfunctions, and disorders associated with perfectionism. The third stream involves our interest in developing conceptual models of how and why perfectionism develops and of how and why perfectionism is associated with pernicious outcomes. Finally, the fourth stream involves the development, evaluation, and refinement of a treatment for perfectionistic behaviour. Although the presentation of the streams will sound sequential, the various streams were worked on simultaneously over the years. I will discuss, briefly, these domains of our work.

A Descriptive Model of Perfectionism

An understanding of perfectionism is an ever-evolving process and one that is continuously informed by all of the streams of research that I will describe. We have articulated a descriptive model known as the Comprehensive Model of Perfectionistic Behaviour (CMPB; Hewitt et al., 2017) to aid in our understanding of the construct. The components of the CMPB have their roots in the clinical world where patients' behaviour, as well as extant writings and case studies, contributed significantly to the conceptualisation. Moreover, a substantial amount of research investigat-

¹ Although I am currently the Director of Clinical Training at a clinical program designated as Clinical Science program, for some reason, for me personally, scientist practitioner seems to be a term that feels better. The scientist practitioner model or Boulder model places equal importance of extensive training in research skills and abilities and clinical work. The scientist practitioner is a clinical psychologist who uses both domains of knowledge and skill in all their work, with clinical work influencing the research and the research influencing the clinical work.

ing the validity of the components of the CMPB has been completed and research efforts continue to evaluate its utility and refine its components. Although there are other conceptualisations and combinations of conceptualisations of perfectionism, broadly we see perfectionism as, on the one hand, a broad multifarious personality or relational style and, on the other hand, a way of being or existing in the world where one interacts with others and with one's self. It is not simply a set of attitudes or cognitions or obsessionism or conscientious achievement striving. We conceptualised perfectionism as a multifaceted and multilevel personality style with three major interacting components that emphasise the relational, psychodynamic, and motivational elements of perfectionism. The CMPB's overarching components or levels include:

- (1) The trait level, with dimensions representing dispositional factors that reflect the requirement of perfection (i.e., the need to be perfect) for the self and others (Hewitt & Flett, 1991, 2004). The traits function like other traits, providing consistent and stable energy and drive for behaviour.
- (2) The other-relational or interpersonal level, with facets reflecting the presentation of one's purported perfection to others and the world more generally (i.e., the need to appear perfect; Hewitt et al., 2003). Whereas the perfectionism traits reflect the content of perfectionism, the other relational level reflects the process or interpersonal expression of the traits.
- (3) The self-relational or intrapersonal level reflects the internal expression of the need for being or appearing perfect in the form of an internal self-dialogue that involves automatized perfectionism-themed self-relational statements (Flett, Hewitt, Blankstein, & Gray, 1998), harsh self-recriminations and judgments, as well as elements of self-neglect and lack of self-soothing and self-care (Hewitt et al., 2020).

Although the components are described separately, the degree to which any given individual experiences each of these components is both variable and shifting, resulting in a myriad of potential constellations and patterns. Therefore, there is no singular prototypic perfectionistic individual. I will describe very briefly each of the dimensions and facets comprising the perfectionism components.

Perfectionism traits. The first component of the CMPB is composed of three trait dimensions, all of which are intercorrelated, although individuals may vary in terms of scoring high in all or just one or two trait dimensions. They include the following:

Self-oriented perfectionism. Self-oriented perfectionism involves the requirement of absolute perfection of the self (see Hewitt & Flett, 1991, 2004). The perfectionistic and unrealistic expectations, concern with mistakes, and self-critical evaluations are generated by and directed toward the self (Hewitt & Flett, 2004). The self-oriented perfectionist equates worth and cohesion with attaining perfection and avoiding imperfection. Given the impossibility of this feat in reality, self-oriented perfectionists experience themselves as never good enough and as having failed—deserving of self-admonishment and the accompanying negative affect. These negative affects further fuel their shame and self-hatred, as self-oriented perfectionists typically do not tolerate

anything but perfection. Their preoccupied pursuit of perfection can paradoxically inhibit behavioural striving for some: fearing failure with its attendant self-recriminations, the individual may withdraw into avoidance and fantasies of perfection that provide no route to actual mastery experiences.

Other-oriented perfectionism. Other-oriented perfectionism is an externally directed trait involving expectations of and requirements for others. Rather than requiring the self to be perfect, other-oriented perfectionists require others to be perfect, although they can of course co-occur. This perfectionist tends to direct demands for perfection toward significant individuals or groups within the individual's social surround, harshly evaluating others' inevitable shortcomings with disdain and contempt. Interpersonal relations for the other-oriented perfectionist are likely fraught with the potential for the perfectionist's targets to feel personally inadequate, highly criticised, and pushed away. By requiring others to be perfect, the other-oriented perfectionist may vicariously experience perfectionistic strivings through others as proxies for the self, involving a diffusion of boundaries between the self and others (Roxborough, Hewitt, Flett, & Abizadeh, 2009).

Socially prescribed perfectionism. In contrast to internally motivated requirements for perfection, socially prescribed perfectionism reflects the belief that others demand or expect perfection of the self. These individuals typically perceive the presence of powerful external demands for perfection from family members, friends, acquaintances, or society at large. This perception or belief may or may not be veridical, although there is some indication that socially prescribed perfectionism is associated with the perfectionism dimensions of parental criticism and parental expectations (Frost, Marten, Lahart, & Rosenblate, 1990). The motivation behind socially prescribed perfectionism is relationally driven, with needs of securing acceptance, belonging, and love, while avoiding rejection and abandonment (Hewitt et al., 2017; Hewitt, Flett, Sherry, & Caelian, 2006). Such motivation is most easily seen with socially prescribed perfectionism but these same relational motives are evident beneath the surface in both self- and other-oriented perfectionism. For the perfectionistic individual, however, needs for connectedness and security are seldom satisfied and others are experienced not as sources of support and acceptance but of unrelenting expectations, harsh judgments, and stress.

Interpersonal components of perfectionism self-presentation. Individuals differ in their interpersonal expression of their need for perfection. Perfectionistic self-presentation represents a dynamic interpersonal process of displaying one's purported perfection or concealing one's imperfections. Thus this component of perfectionistic behaviour refers not to the individual's need to be perfect, but to the drive to appear perfect to others (Hewitt et al., 2003). The focus on an outward appearance of flawlessness—as opposed to inner preoccupations with and strivings for the perfection of the self—distinguishes perfectionistic self-presentation from the trait components mentioned above. This way of functioning is nevertheless maladaptive, as the perfectionistic self-presenter tends to feel inauthentic—as though an imposter—and anxiously vigilant, sensitive, and responsive to others' impressions of them. Thus, perfectionistic self-presenters view the interpersonal encounter as risky, leading to avoidance, and others may experience them as unrelatable, unreachable, or unlikeable (Hewitt, Habke, Lee-Baggley, Sherry, & Flett, 2008). Consequently, perfectionistic self-presentation creates the opposite of the

desired effect—rather than gaining acceptance, they push others away (Hewitt et al., 2006, 2017; Hewitt, Flett, et al., 2018; Sherry, Law, Hewitt, Flett, & Besser, 2008; Sherry, Mackinnon, & Gauthreau, 2016). Connecting all the interpersonal expressions of one's perfection is the individual's experience of loneliness, inauthenticity, disconnection, and an absence of intimacy. There are three facets to perfectionistic self-presentation:

Perfectionistic self-promotion. This self-presentational style involves actively promoting a perfect image of themselves to others. They present a picture of being exceptionally capable, competent, successful, admirable and so forth, and look for opportunities to impress others (Hewitt et al., 2003). Interpersonally, the perfectionistic self-promoter appears highly self-focused, often responding to conversation in a self-referent manner. For the perfectionistic self-promoter, interpersonal encounters are competitive arenas in which connection is sought by having to come out on top. This is reminiscent of an interpersonal presentation of narcissistic individuals and, indeed, this facet of perfectionistic self-presentation is associated with narcissism (Sherry, Hewitt, Flett, Lee-Baggley, & Hall, 2007).

Nondisplay of imperfection. This interpersonal style includes avoidance or concealment of any behaviour that could be judged by others as imperfect. These individuals attempt to protect a perfect image of themselves by preventing any imperfections from being detected by others. Their primary defense is that of compartmentalization, coupled with an interpersonal stance characterised by selective sharing of self. Although this may contribute to acceptance in the early stages of relationship, others eventually experience these individuals as superficial or one-dimensional. Their relational world is comprised of distinct social circles that seldom intersect and in which they may appear and behave in very different ways intended to ensure acceptance within each arena. These individuals appear to have a restricted or chameleon-like quality whereby they withhold demonstrations of an imperfection that they believe others might become aware of. Thus they adjust their manner of relating and what they reveal of themselves according to their perception of what will gain acceptance and admiration.

Nondisclosure of imperfection. This interpersonal style is similarly passive and concealing, but the focus is to avoid verbally disclosing any imperfections to others. For these individuals, the primary defenses are externalization and deflection. In contrast to perfectionistic self-promoters, their conversation is about others rather than self. An individual high on nondisclosure of imperfection may be quite engaging interpersonally, but the receiver will come away from the encounter feeling he or she really does not know the individual.

Intrapersonal or self-relational components of perfectionism. In addition to an interpersonal component in perfectionism, we also emphasise an intrapersonal or self-relational component in perfectionism. While perfectionism is viewed as a broader construct, key cognitive processes can be identified as a component of the perfectionism construct. This component of the CMPB is thus intrapersonal: one's automatic cognitive processes and inner dialogue centered on the need to be or seem perfect (e.g., thoughts like "I have to be perfect"), and on self-recriminations (e.g., "I am such an idiot") when imperfections inevitably arise. While the other components of the CMPB are stable and dispositional, the self-relational component can present as more state-like,

with these aspects of perfectionism triggered in different contexts, especially situations of perceived risk, shortfalls, or failures. It is in such instances that our model differs from strictly cognitive models. Critical to the conceptualisation is an appreciation that a self-critical and demanding inner dialogue is intricately intertwined with feelings and behaviours toward the self. In psychodynamic terms, this is referred to as one's introject, or one's relationship with self. Affectively, this may include feelings of despair and disgust stemming from self-hate or self-loathing. Behaviourally, there may be self-neglect, self-sabotage, self-harm, or in extreme cases, attempts at self-annihilation.

Thus, our descriptive model of perfectionism reflects our view of the complexity of this personality style with many forms and levels of perfectionistic behaviour. As indicated, due to the various combinations of the components, there can be different manifestations and clinical presentations of perfectionistic behaviour.

What Is Perfectionism Associated With?

In addition to providing a descriptive model of the perfectionism construct we also attempted to determine predicted outcomes associated with these components. Considerable research has demonstrated that perfectionism can both directly and indirectly (Hewitt & Flett, 2002) influence an individual's vulnerability to and manifestation of a variety of painful and maladaptive problems (see Hewitt et al., 2017; Shafran, Cooper, & Fairburn, 2002; Sirois & Molnar, 2016).

In our work and the work of many others in the field, we predicted that the different components would be related differentially to various outcomes and, over the years, the extensive perniciousness of perfectionism has been demonstrated again and again. In Table 1, I have provided a list of some of the outcomes of perfectionistic behaviour that have been empirically demonstrated either in replicated findings or from meta-analyses that have been conducted. This is by no means an exhaustive list; it is simply provided to illustrate that perfectionism is indeed pernicious in terms of psychological/psychiatric symptoms and diagnoses, physical health problems, relationship problems, and achievement problems that are associated with perfectionism.

Although there are numerous very severe maladaptive problems in the list, perhaps some of the most disturbing reflect the associations of socially prescribed perfectionism with suicide behaviours in adults, adolescents, and children. These behaviours include suicide ideation, clinician ratings of suicide risk, and suicide attempts (see Flett, Hewitt, & Heisel, 2014). Second, the findings by Dr. Prem Fry (Fry & Debats, 2009) regarding the association between self-oriented perfectionism and early death also underscore the seriousness and importance of perfectionism in negative outcomes.

Likewise, Table 1 presents outcomes that suggest that perfectionism has a direct role in its association with negative outcomes; some more recent work suggests that perfectionism can be even more problematic for individuals. The implication is that perfectionism may create a vulnerability to various negative outcomes and these outcomes are often severe enough to warrant some kind of intervention. Importantly, in some of our (and others) recent work we have shown that perfectionism also interferes with the process of seeking, initiating, maintaining, and benefitting from treatment. For example, socially prescribed perfectionism and the

Table 1
Selected Outcomes of Perfectionism

Problems associated with perfectionism	Outcomes
Psychological/psychiatric problems	Unipolar depression, suicide behavior, eating disorders, anxiety disorders, personality disorders
Relationship problems	Marital satisfaction, intimacy/sexual problems, negative social interactions, poor help seeking
Physical problems	Stress reactions, chronic headaches, sleep problems, somatic anxiety, early death
Achievement problems	Procrastination, self-handicapping, fear of failure, underachievement, writing problems, imposterism, burnout

need to appear perfect in particular seem to be associated with negative attitudes toward seeking help with professionals, fears of psychotherapy and therapists, increased anxiety in initial clinical interviews, and with reduced benefit in both individual and group therapy (Hewitt et al., 2008, 2020; Hewitt, Chen, et al., 2019; Zuroff et al., 2000). Moreover, in a paper just accepted (Hewitt, Chen, et al., 2019), we have shown that clinicians tend to have more negative judgments and impressions of perfectionistic patients suggesting that the therapeutic alliance (the most important predictor of good therapy outcome) might be compromised by perfectionistic behaviour of patients, thus influencing less than optimum outcomes. So perfectionism not only has direct effects in its association with psychological, physical, relationship, and achievement problems, it also has a more indirect effect by influencing whether the perfectionistic person seeks out or benefits from treatment.

The myriad of problems that are connected with perfectionism have been evident for some time and, in fact, is the most broadly researched stream of perfectionism work. Based on the number and types of problems associated with perfectionism, several researchers have described perfectionism as a transdiagnostic variable (Bieling, Summerfeldt, Israeli, & Antony, 2004; Shafran & Mansell, 2001) that underlies various *Diagnostic and Statistical Manual (DSM)*-based diagnoses. Although we agree that perfectionism can be transdiagnostic, we prefer to use the term *core vulnerability factor* rather than transdiagnostic because perfectionism appears to be associated with many maladaptive outcomes not just diagnoses, especially diagnoses from a *DSM* perspective. Moreover, although I have been approached to argue that perfectionism should be viewed as a diagnosis *à la DSM*, I have resisted such a characterization as it appears to be much broader than a diagnosis and affects all manner of diagnoses and other issues. If there ever was a problem with comorbidity in the *DSM* system (and there is), adding perfectionism as a disorder would obviously compound this problem dramatically.

The Perfectionism Social Disconnection Model

Development. One of the fundamental questions when investigating a core vulnerability factor such as perfectionism is where does it come from and how does it arise. We recently updated and extended an earlier model (Hewitt et al., 2006), now known as the Perfectionism Social Disconnection Model (PSDM; Hewitt et al., 2017). This dynamic-relational model includes two parts; one addressing the relational context of the development of perfectionism and the second addressing the potential causal and maintenance roles perfectionism plays in producing negative outcomes. The PSDM developed out of a stress generation model (Hewitt &

Flett, 2002) we posited in our 2002 edited book (Flett & Hewitt, 2002) and reflected the generation of a particular type of stress or failure, namely social disconnection and alienation. It places a particular emphasis on interpersonal/relational dynamics and draws on the empirically supported insights of attachment theory (Bowlby, 1988; Eagle, 2017) and self psychology (Kohut, 1971), with perfectionism developing within an early relational context. In this model, failures or poor fit between the child's needs and the caregiver's responses—which we refer to as *asynchrony*—creates the conditions for perfectionism to develop.² In particular, the unmet needs central to developing perfectionism are (a) the need to belong and (b) the need for self-esteem. These needs are viewed as being thwarted in early development and can continue to be unmet throughout the person's life. Thus, perfectionism evolves both to prevent rejection/abandonment and promote acceptance, connection, and fitting in the world, while also repairing a sense of defectiveness aimed at bolstering ego strength and self-cohesion.

Essentially, the development of perfectionism involves the experience of asynchrony in the caregiver relationship (e.g., difficulties in the child's expressive abilities, the caregivers' receptive capacity, or both) creating attachment anxiety that is moderated by constitutional factors (e.g., an anxious temperament). This shapes the child's internal model of others to be rigidly represented as unavailable, critical, or incapable. Similarly, asynchrony disturbs the child's internal model of the self to be rigidly represented as fragile, fragmented, defective, or loathsome. These internal person schemas are associated with painful affective states such as shame, anxiety, depression, or anger—connected to the anticipation or actual experience of humiliation, rejection, or abandonment. Con-

² I do not wish to assert that parents are to blame for a person's struggles with perfectionism and the attendant difficulties. Nor would I suggest that parents of perfectionists are necessarily defective in their parenting or neglectful in their interactions with their child. Rather, we adhere to views consistent with those posited by Gabbard (2004) who stated that:

Our knowledge of genetics and cognitive neuroscience suggests that the genetically based temperament of the child shapes much of the interaction with the parents. Characteristics that are inherited evoke specific parental responses (Reiss et al., 1995). The behavior of the parents, in turn, shapes the child's personality. In this regard, it is an oversimplification to blame parents for their children's problems. A complex interaction between the child's inherent traits, the parents' psychological characteristics, and the 'fit' between parent and child is crucial to the developmental perspective. (Gabbard, 2004, p. 7)

Moreover, the important elements of the interactions in producing insecure attachment involve a mismatch or asynchrony between caregiver and child.

sequently, the individual faces the world with this distorted perceptual lens, experiencing current and future interpersonal encounters as inevitably wounding and rejecting, despite longing for acceptance and affirmation.

Perfectionism represents a particular set of strategies employed to cope with this situation, with the aim of repairing the damaged self through the individual's attempt to become or to appear perfect, in hopes of gaining acceptance and affirmation (Hewitt et al., 2017). The individual lives his or her life in accord with the motivation: "If I am perfect, there will be nothing to criticise, to judge or to reject—nothing to be ashamed of—and I will be accepted, I will be whole, and I will have worth" (Hewitt et al., 2017, p. 101). In short, perfection promises to satisfy the needs of belonging and self-cohesion and esteem; unfortunately, this solution reinforces an insecure attachment style that involves compromised, inflexible, rebarbative, and maladaptive interpersonal interactions that distance, alienate, and annoy others, producing the disconnection and rejection that the perfectionist was working so hard to avoid (Hewitt et al., 2006, Hewitt, Flett, et al., 2018). The development of perfectionism can further be reinforced throughout individuals' lives in subsequent relational experiences coloured by their internal working models of self and others. Thus, relationships shape internal working models, and internal working models shape relationships.

We have begun conducting research to evaluate this model and work within my lab with two of my graduates students, Ms. Chang Chen and Ms. Ariel Ko, has been providing initial evidence suggesting that the model is promising (e.g., Chen et al., 2012; Chen, Hewitt, & Flett, 2015; Ko, Hewitt, Cox, Flett, & Chen, 2019; and also see Wei, Mallinckrodt, Russell, & Abraham, 2004).

Maintenance and cause. The second part of the PSDM posits that perfectionism generates subjective and objective social disconnection, which in turn confers a vulnerability for adverse mental and physical health outcomes as well as relationship and achievement problems. Subjective social disconnection reflects the perception that others are not interested in connecting and involves heightened rejection sensitivity, the belief that others are overly judgmental, and a view of the self as irrelevant to others (Cha, 2016; Chen et al., 2015; Flett, Besser, & Hewitt, 2014; Flett, Hewitt, & De Rosa, 1996). Objective social disconnection reflects the veridical reality that other people often avoid and reject perfectionists due to their off-putting behaviours such as coldness, self-concealment, passive-aggressiveness, hostility and excessive reassurance seeking (Haring, Hewitt, & Flett, 2003; Hewitt et al., 2003; Kawamura & Frost, 2004). Moreover, the PSDM asserts both subjective and objective social disconnection contribute to intense feelings of alienation and this rejection, whether real or perceived, painfully reminds perfectionists of their flawed sense of self.

In all of these interpersonal patterns of perfectionism, individuals use relationships (both with self and with others) to attempt to correct their unmet needs. However, these interpersonal styles inevitably produce the opposite effect, creating disconnection and distress (Chang, Sanna, Chang, & Bodem, 2008; Chen et al., 2012; Hewitt et al., 2006, 2017), a perfect example of the neurotic paradox! Consequently, perfectionism's allure to solve their need for belonging and self-esteem is a false promise that often ends in self-generated emotional pain.

Moreover, the social disconnection arising from perfectionistic behaviour may serve an additional, unconscious motive: to protect the individual from intimate connections perceived to result in rejection. The perfectionist longs for connection, believing that perfection will deliver it, yet at the same time fears that being truly known by another—flaws included—would risk exposure to contempt and eventual abandonment (Hewitt et al., 2017). It is thus clinically useful to consider the degree to which an individual's perfectionistic features may represent an unconscious compromise formation between the seeking of acceptance and attachment, and an effort to avoid dreaded yet anticipated rejection.

The social disconnection and alienation arising from perfectionism not only occur in personal, professional, and intimate relationships. Hewitt, Flett, and colleagues (2018) also indicated that the PSDM mechanisms are relevant for the clinical context as well. As indicated earlier, perfectionistic behaviour seems to create problems with clinicians and with the clinical process and PSDM has been extended to help understand this process. In describing the PSDM in a clinical context, it was theorized that the subjective and objective social disconnection generated by perfectionism interferes with the establishment and maintenance of the therapeutic alliance that subsequently stifles treatment progress. Indeed, perfectionistic patients project emotions and relational expectations stemming from social disconnection onto the therapist. For instance, patients with elevated socially prescribed perfectionism are hyper-vigilant to perceived signs of rejection and, as such, are often hesitant to disclose information they believe will cause the therapist to rebuff them. Likewise, the rebarbative interpersonal behaviour generated by trait perfectionism dimensions can cause therapists to disconnect from patients (Hewitt, Mikail, Flett, & Dang, 2018).

Evidence in support of this portion of the PSDM is accumulating. For example, Hewitt, Flett, and Mikail (1995) reported that pain patients rated other-oriented perfectionistic spouses as less supportive, and both Dunkley, Blankstein, Halsall, Williams, and Winkworth (2000) and Sherry et al. (2008) found low perceived social support mediated the relationship between socially prescribed perfectionism and depression symptoms. Furthermore, Nepon, Flett, Hewitt, and Molnar (2011) reported that undergraduates with elevated socially prescribed perfectionism had higher rejection sensitivity, and that rejection sensitivity, in turn, mediated the effects of socially prescribed perfectionism on depression symptoms and social anxiety. Likewise, Roxborough et al. (2012) demonstrated that social hopelessness mediated the relationship between socially prescribed perfectionism and suicide potential in child and adolescent outpatients. Finally, Smith et al. (2017) found self-oriented and socially prescribed perfectionism in daughters, as well as other-oriented perfectionism in mothers, predicted increased depression symptoms in daughters through a negative relationship with daughters' social self-esteem.

Treatment of Perfectionism

Although there is substantial evidence of the problems that arise from perfectionism, the problems or diagnoses do not form the basis for the treatment. Rather the focus or basis of the treatment is on the dynamic and relational underpinnings of perfectionism and the attendant difficulties. Thus, our treatment is formulation-driven; that is, the treatment and the tasks of treatment are based

on the unique and idiosyncratic model of how the person's perfectionism is manifest, how it arose in this individual's life, the purpose it served and currently serves, how it holds the promise of positive outcomes like belonging and repairing, and the costs and outcomes.

A detailed description of the treatment is beyond the scope of this paper and the interested reader is directed to our 2017 book (Hewitt et al., 2017) and to Hewitt, Mikail, et al. (2018) for more details about clinical assessment, development, and use of the formulation in individual and group treatment, and the dynamic-relational interventions appropriate over the course of those treatments.

Briefly, this treatment model emphasizes the relational basis of human behaviour, particularly the need for belonging and self-esteem, and focuses on how perfectionistic behaviour offers a false promise of securing these needs. Thus, treatment aims to first develop awareness regarding the relational dynamics and unique interpersonal patterns underlying their need for perfection. The clinician can then help the patient move toward more adaptive and flexible ways of securing these needs of belonging and self-esteem.

Treatment begins with a complete psychodiagnostic assessment and a discussion of the clinical formulation (see Hewitt, Mikail, et al., 2018) with the patient, describing the individual's unique story aimed at helping the patient understand the development of their perfectionistic behaviour as a strategy to attain their needs for belonging and self-esteem. The formulation also identifies disconnection and distress as consequences of their perfectionistic behaviour. Although the formulation is provided to the patient, this presentation is not enough to effect change in the person. As treatment progresses, the patient builds a deeper experiential connection to the formulation (and refinements to the formulation), which allows for the consideration of more flexible and adaptive patterns of relating to self and others. As perfectionists tend to prefer information over emotional experience, the clinician needs to ensure that the patient's learning in therapy does not remain merely at the didactic or cognitive level, but includes experiential learning through the therapeutic relationship, expression of emotion, and revealing of the self in order to promote real growth. The clinician can use the formulation as an evolving model of the individual that can be tested collaboratively as new material emerges (e.g., past and current behaviour, dynamics, and life problems).

An overarching goal is to shift the patient's interpersonal position toward a more flexible acceptance of both self and others, but especially acceptance of and trust in the self. As treatment progresses, the patient can work toward engaging in more adaptive behaviours that are more aligned with his or her own intrinsic desires and needs, while tolerating the accompanying anxiety. The patient then internalizes the new ways of relating with the therapist and others to revise their internal models of self and others, negating the need for maladaptive patterns of defending and relating. Key to all these scenarios is the therapist's ability to observe the process in terms of here-and-now microevents, and to use transference and countertransference responses in order to bring attention, empathy, and understanding to the patient's maladaptive interpersonal behaviours.

We have demonstrated the effectiveness of this treatment with two studies assessing perfectionism components and distress in a

group psychotherapy. The first study (Hewitt et al., 2015) based on self-report of patients, showed that all components of perfectionism were clinically improved at follow-up and that the improvement continued throughout the follow-up period. In addition, we also showed similar results using informant reports of close others (Hewitt, Qiu, et al., 2019). Moreover, a randomized controlled trial is underway for our group psychotherapy and we are in the process of assessing the effectiveness and efficacy of our treatment in an individual format.

Things Learned Along the Way

Over the years, my colleagues and I have learned not only many things about perfectionism but also about the process of trying to develop a real understanding of the psychological phenomena we study. We have had some hilarious experiences like having the initial colour photo advertisements of our 2002 edited book cover (Flett & Hewitt, 2002) with the title spelled wrong (Perfectionism was spelled Pefectionism in the advertisements) and many other experiences like those below.

Early Ideas

If any undergraduates read this paper, the genesis of this work started when I was a third-year undergraduate and I needed to write a paper for a personality course. I came upon in a magazine some writing that suggested that perfectionism was a difficulty for the author. I thought that this might make a possible paper for the course and found out, rather quickly, that although there were writings on perfectionism, there was no empirical work that I could find that looked at perfectionism. So, my first paper on perfectionism was for a course assignment and that paper led to my first study in an honours thesis that I had hoped would be the first empirical publication on perfectionism to be published (i.e., Hewitt & Dyck, 1986). It was not. Another paper came out that same year by a Canadian academic at the University of Regina, who was similarly interested in perfectionism and depression (Pirrot, 1986). In any event, that third-year paper led to my honour's thesis, master's thesis, doctoral dissertation, and a program of research that I have been excited about for over 30 years. I should mention that a review of my first publication did much to humble and galvanize me as, unbeknownst to me, my writing and conclusions in that paper were not in agreement with quite a famous psychologist reviewing the paper (he signed his name to the review—just to put me in my place!) indicated that “the author cannot distinguish between fact and fiction.” With that nasty comment, I (I was an undergraduate do not forget) immediately thought that I was barking up the wrong tree with inappropriate ideas. However, after some reflection, I thought if I annoyed a famous psychologist with my writing and ideas, maybe I was on to something. I wound up going with the latter interpretation.

Looking Underneath

As stated earlier, my psychodynamic training and my adherence to thinking psychodynamically has been infused in the research and clinical work. Often in our field there is a surface level of focus and understanding of perfectionistic behaviour, whether it is constructs versus people, thinking of perfectionism exclusively as

an attitude, or focusing solely on symptom reduction as the treatment goal or as a measure of treatment success. A psychodynamic researcher and clinician seems always to be looking underneath behaviours to try to understand where they come from, what is driving the behaviour, what purpose the behaviour serves, how it developed or showed up in the person, and, ultimately, how to change the behaviour to increase the person's quality of life and resumption of growth. Our dynamic-relational approach hopes to honour both the complexity and depth of the person as well as the underpinnings of behaviour in our conceptualisation, models, and treatment.

At this point, I would like to say, again, that all of our work, very generally, has been on trying to understand what perfectionism is in its broadest sense. So, in an effort to try to answer a question posed to me more often than I can count, I will give a penultimate or current statement of what I believe perfectionism is (there may be changes to this as the work continues). I would say that perfectionism is a personality/relational characterological style that arises out of early relational experiences and is maintained by enduring relational contexts. The need to be or appear to be perfect is a defensive position and serves, in a costly and ineffective manner, the purpose of attempting to solve problems of not fitting, not belonging, not being accepted or mattering to others, and problems of feeling, at the core, not good enough, flawed, defective, fragile, and unworthy. It is multifaceted and multilayered and infuses all manner of one's behaviour. Hence, it is a way of being or existing in the world that costs dearly. I would have said this at the start, but I believe that I needed to describe the streams of our work for it to make sense.

Perfectionism in the Canadian Context

As I mentioned at the outset, when I first began work in this field there were no empirical papers that I could find, and Cana-

dians (Michael Pirot, Dennis Dyck, who was my coauthor, and I) published two of the first empirical works on perfectionism in 1986. This indicates that at least three Canadian researchers in the early 1980s shared an interest in perfectionism and that interest has burgeoned since then with many Canadian psychologists sharing an interest in this area. One important feature of perfectionism research that I would like to underscore is the role that Canadian psychologists have played in its research and in demonstrating its importance. In fact, a reporter from the *New York Times*, in her research on a project dealing with perfectionism, stated to me that "the Canadians are certainly at the forefront in this important area of research." The number of papers on perfectionism have burgeoned over the years (I have not counted but they would number in the thousands) and Canadian researchers have played an extremely important role. At the risk of missing someone, I have listed many of these researchers in Table 2, and I would like to thank them for their work in helping to understand this important core vulnerability factor. There are, I assume, younger researchers who will make a later version of this list and I encourage them to continue this research as there is no shortage of hypotheses to test.

As mentioned in Hewitt et al. (2017), there is a certain joy one gets from working alongside and collaborating with very intelligent and creative people when trying to solve problems such as attempting to understand aspects of human personality. Moreover, there is another joy in sending ideas, models, and proposals out to the research and clinical community and having them (whether they agree with some of the ideas or whether they are vehemently opposed to them) consider the ideas, potentially gather data to test the ideas and ultimately accept or refute them. A testable model (idea) is a success in science if others scientifically test it. We hope that our focus has aided in developing successful models that others can consider. Whether they are accurate representations of truth is a much more involved process. Maybe this is what was

Table 2
Canadian Psychologists Studying Perfectionism

Name	Affiliation
Antony, Martin	Ryerson University
Bieling, Peter	McMaster University
Chen, Chang	University of British Columbia
Cox, Brian*	University of Manitoba
Crocker, Peter	University of British Columbia
Dunkley, David	McGill University
Dunn, John	University of Alberta
Flett, Gordon	York University
Fry, Prem	Trinity Western University
Gaudreau, Patrick	University of Ottawa
Gotwals, John	Lakehead University
McKinnon, Sean	Dalhousie University
Mikaïl, Samuel	Waterloo University and Sunlife Assurance
Molnar, Danielle	Brock University
Mushquash, Aislin	Lakehead University
Rheaume, Josee	Centre Hospitalier Affilié Universitaire Hôtel-Dieu de Lévis
Saklofske, Don	University of Western Ontario
Sherry, Simon	Dalhousie University
Sirois, Fuschia	University of Sheffield
Smith, Martin	York St. John University
Zuroff, David	McGill University

* Deceased.

meant by that reviewer so long ago in terms of distinguishing fact from fiction.

Résumé

Cet article vise à étoffer l'allocution que j'ai prononcée au congrès annuel de la Société canadienne de psychologie, à Halifax, en Nouvelle-Écosse, le 31 mai 2019, lorsqu'on m'a décerné le Prix Donald O. Hebb pour contributions remarquables à la psychologie en tant que science. J'y présente quelques idées de mes collègues, en particulier Gordon Flett et Samuel Mikail, et de moi-même ainsi que les travaux que nous avons entrepris afin de mieux comprendre le perfectionnisme, un important facteur de vulnérabilité associé à une foule de difficultés psychologiques, physiques, relationnelles et de réalisation. Il convient de souligner que ma perspective fondée sur des pratiques interpersonnelles et psychodynamiques a grandement influencé la recherche et les travaux cliniques découlant de notre démarche, qui comporte de façon générale plusieurs grands axes de recherche. Ces axes comprennent la conceptualisation du perfectionnisme; la détermination des types de détresse, de dysfonctionnement et de trouble associés au perfectionnisme; la façon dont le perfectionnisme se manifeste et les mécanismes par lesquels il crée des difficultés; enfin, la mise au point, le perfectionnement et l'évaluation d'une approche psychothérapeutique relationnelle dynamique pour traiter le comportement perfectionniste. J'aborde également de façon sommaire les connaissances que nous avons acquises sur le perfectionnisme, mais aussi ce que nous a appris notre démarche visant à comprendre un facteur de vulnérabilité lié à la personnalité qui est complexe et multidimensionnel. Enfin, je conclus en soulignant le travail de chercheurs canadiens de talent de partout au pays qui, comme nous, ont été captivés par l'étude du perfectionnisme et nous ont grandement aidés à comprendre le concept.

Mots-clés : perfectionnisme, comportement perfectionniste, perfectionniste, psychodynamique.

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